Some providers and costs are exempt from prospective payment.

1. The following are subject to retrospective cost reimbursement principles:

   A. Hospitals in rural and very rural counties in Montana, effective July 1, 1993. Rural and very rural counties are identified by the United States Department of Agriculture in their urban to rural continuum.
   B. Neonate services under DRGs 385-389 provided in neonatal intensive care units of Montana hospitals are exempt from the Medicaid DRG payment system and will be reimbursed using a retrospective cost-based system effective July 1, 1993. Interim payments will be based on facility charges times the facility cost-to-charge ratio determined from submitted cost reports.
   C. Rehabilitation units of acute care hospitals. These units will be issued a distinct Medicaid provider number. Units will be required to submit a cost report, on an annual basis after the provider fiscal year end, detailing the costs of providing these services.
   D. Medical Education related costs as defined by Medicare.
   E. Certified Registered Nurse Anesthetists costs as defined by Medicare.
   F. Critical Access Hospitals as licensed by the State.

2. Hospitals located more than 100 miles from the Montana border are reimbursed 50% of billed charges for medically necessary services for date of admission on/after April 1,2002.

3. Hospital based inpatient psychiatric services for individuals under age 21, provided in hospital based psychiatric residential treatment facilities, as defined in service 16 of the supplement to attachments 3.1A and 3.1B of Montana's State Medicaid plan, shall be reimbursed an all-inclusive per-diem rate as established in Part P below.

D. REASONABLE COST REIMBURSEMENT

Hospitals, units and costs exempt from prospective payment will continue to use the Title XVIII retrospective reasonable cost principles for reimbursing Medicaid inpatient hospital services. Allowable costs will be determined in accordance with generally accepted accounting principles as defined by the American institute of Certified Public Accountants. Such definition of allowable costs is further defined in accordance with the Medicare Provider Reimbursement Manual, HCFA Pub. 15-1, subject to the exceptions and limitations provided in the Department's Administrative Rules. Pub. 15, is a manual published by the United States Department of Health and Human Services, Health Care Financing Administration, which provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended.

P. PER-DIEM REIMBURSEMENT

For hospital based inpatient psychiatric services for individuals under 21 provided in Montana, the Montana Medicaid program will pay a provider, for each Medicaid patient day, a bundled per diem rate, less any third party or other payments. The statewide bundled per diem rate for hospital based inpatient psychiatric services provided by all Montana providers is the lesser of:

(a) the amount specified in the department's Medicaid mental health fee schedule; or
(b) the provider's usual and customary charges (billed charges).

Medicaid payment is not allowable for treatment or services unless provided in a hospital based psychiatric residential treatment facility as defined in service 16 of the supplement to attachments 3.1A and 3.1B of Montana's state Medicaid plan, and unless all other applicable requirements are met.

The per diem rate provided above for hospital based psychiatric residential treatment facility providers located in the state of Montana is the final rate, and such rate will not be adjusted retrospectively based upon more recent cost data or inflation estimates. Cost settlements will not be performed. The per-diem rate is an all-inclusive bundled rate. Except as provided in (a) and (b) below, the per diem payment rate covers and includes all psychiatric services, all therapies required in the recipient's plan of care, and all other services and items related to the psychiatric condition being treated, that are provided while the recipient is admitted to the hospital based residential treatment facility, including but not limited to services provided by licensed psychologists, licensed clinical social workers, and licensed professional counselors, and lab and pharmacy services. These services must be reimbursed from the provider's all-inclusive rate except as provided in (a) and (b) below, and are not separately billable.

(a) The professional component of physician services is separately billable according to the applicable rules governing billing for physician services.
(b) Services and items that are not related to the recipient's psychiatric condition being treated in the psychiatric residential treatment facility and that are not provided by the psychiatric residential treatment facility are separately billable in accordance with the applicable rules governing billing for the category of services or items.

Reimbursement will be made to a hospital based psychiatric residential treatment facility provider for reserving a bed while the recipient is temporarily absent only if:

(a) the recipient's plan of care documents the medical need for therapeutic home visits as part of a therapeutic plan to transition the recipient to a less restrictive level of care;
(b) the recipient is temporarily absent on a therapeutic home visit;
(c) the provider clearly documents staff contact and recipient achievements or regressions during and following the therapeutic home visit; and

(d) the recipient is absent from the provider's facility for no more than three patient days per absence.

No more than 14 patient days per recipient in each rate year will be allowed for therapeutic home visits.

All Montana providers of hospital based inpatient psychiatric services for individuals under age 21 shall be eligible to receive, in addition to per-diem reimbursement, an annual continuity of care payment. The continuity of care payments will completely or partially reimburse providers for their otherwise un-reimbursed costs of providing care. Total Medicaid payments to a provider of hospital based inpatient psychiatric services for individuals under age 21 will not exceed the Medicaid costs of that provider.

The amount of the continuity of care payment for each qualifying provider will be determined based upon the following formula:

$$CCP = [M/D] \times P$$

Where:

1. CCP equals calculated continuity of care payment.
2. M equals the number of Medicaid days provided by the facility for which the CCP is being calculated.
3. D equals the total number of Medicaid days provided by all facilities eligible to receive a CCP.
4. P equals the total amount to be paid via the Continuity of Care Payment. The State's share of "P" will be the total amount of revenue generated by Montana's hospital utilization fee, less all of the following:
   (A) the amount expended as match for supplemental DSH payments;
   (B) the amount expended as match for HRA 2 payments; and,
   (C) the amount expended as match for HRA 1 payments.

The Medicaid days figures shall be from the department's paid Medicaid claim data for the most recent calendar year that ended at least 12 months prior to the calculation of the continuity of care payments.